# Greater Boston Wellness Collaborative (GBWC)

## HIPAA NOTICE
## OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that I have certain rights to privacy regarding my protected health information I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and followup among the multiple providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information

I understand that changes may be made from time to time and that I may request a current copy of the Notice of Privacy Practices from my clinician.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

_____

Client name Date

_____

Signature Date

OFFICE USE ONLY
I attempted to obtain the client's signature in acknowledgement of this Notice of Privacy Practices Agreement but was unable to do so as documented below: